MEDMUTUAL LIFE™
A Medical Mutual Company

APPLICATION/PARTICIPATION AGREEMENT

Group Number

PART 1: APPLICANT INFORMATION

1. Business Name			Check if applicable: ☐ Partnership ☐ LLC ☐ Subchapter S Corp. ☐ Sole Proprietorship
2. Mailing Address (not P.O. Box)			
Group Contact		Phone ( )	
City	State	Zip	Fax ( )
3. Name of any ☐ Affiliates ☐ Subsidiaries to be covered			e-mail
4. Nature of Business	5. SIC Code	6. Effective Date	7. Initial Rates Guaranteed for _____ months

8. Contributions: **Employer** will contribute:			9. Waiting Period	10. Waiting Period applies to:
Life/AD&D	☐ 100%	☐ Other_____ %	_____	☐ All employees
Voluntary Life and AD&D	☐ 100%	☐ Other_____ %	_____	☐ New employees only
STD	☐ 100%	☐ Other_____ %	_____	
Voluntary Short-Tern Disability	☐ 100%	☐ Other_____ %	_____	
Dependent Life	☐ 100%	☐ Other_____ %		
Long-Term Disability	☐ 100%	☐ Other_____ %		
Other	☐ 100%	☐ Other_____ %		

11. Total eligible employees _____ Total enrolled _____	12. Billing Method: ☐ List Billed ☐ TPA Billed ☐ Self Administered	13. Premium Deposit: (approx. one month's Premium) $_____
14. Premium Payable: ☐ Monthly ☐ Other _____		15. ☐ Premium is due on the 1ST day of each billing period. ☐ Other _____

16. Is any other coverage in force or being applied for as of the effective date of coverage with MedMutual Life Insurance Company?

☐ Yes ☐ No If yes, please explain _____

PART 2: SCHEDULE OF BENEFITS

CLASS DEFINITIONS (if more than one class, definitions must be specific)

Class 1 _____

Class 2 _____

Class 3 _____

Class 4 _____

Employees working less than _____ hours per week are not eligible for coverage unless otherwise noted above.

SELECTION OF COVERAGE(S) (check all that apply and fill in all applicable blanks.)

Class	☐ Basic Life Insurance Amount of Insurance	☐ Basic AD&D Principal Sum	☐ Supplemental Life Amount of Insurance	☐ Supplemental AD&D Principal Sum	☐ Short-Term Disability Maximum Weekly Benefit
1					
2					
3					
4					

1. Weekly STD benefit is subject to a maximum of _____% of employee's Basic Weekly Wage.
2. STD Benefits Payable: _____ day of Accident; _____ day of Sickness for a maximum benefit period of _____ weeks.
3. 1st day Hospital? ☐ Yes ☐ No
4. STD Benefits payable for non-occupational disabilities only.
5. All benefits terminate at retirement unless otherwise noted in class definitions section.
6. STD Benefits not available for employees working in CA, HI, NJ, NY, PR or RI.

SELECTION OF COVERAGE(S) (continued) (check all that apply and fill in all applicable blanks.)

7. Life or AD&D benefits include 24 hour coverage.
8. If Life or AD&D benefits are based upon a multiple of salary, benefits amounts should be rounded to:
   ☐ the next higher multiple of $1,000 ☐ the nearest multiple of $1,000 ☐ other _____
9. Basic Life and AD&D benefits reduce by:
   ☐ 35% at age 65; and further reduces to 50% of the face amount at age 70.
   ☐ 35% at age 65; and further reduces 35% every 5 years thereafter.
   ☐ ___% at age 65; and further reduces to ___% of the face amount at age ____; and further reduces to ___ % of the face amount at age _____.
10. Supplemental Life and AD&D benefits reduce by:
   ☐ 35% at age 65; and further reduces to 50% of the face amount at age 70.
   ☐ 35% at age 65; and further reduces 35% every 5 years thereafter.
   ☐ ____% at age 65; and further reduces to ____% of the face amount at age ____; and further reduces to _____% of the face amount at age _____.
11. Voluntary Life benefits terminate at retirement.

☐ **Group Long-Term Disability**
*Employees must work a minimum of 30 hours per week

Select One Plan:
☐ 90 day elimination ☐ 180 day elimination ☐ Other _____

☐ **Dependent Life Insurance**

Spouse: **$**_____
Child(ren):

$_____ Live birth but less than 14 days

$_____ Age 14 days but less than 6 months

$_____ Age 6 months but less than 21 years

$_____ Age 21 years but less than _____**

**if a full time student(s) and dependent upon the insured for support

☐ **Voluntary Life Insurance**
Increments of $10,000 to a maximum of $300,000

☐ **Voluntary Short-Term Disability**
Increments of $50; minimum of $100 to a maximum of $500, not to exceed 70% of employee's Basic Weekly Wage.

Select One:
☐ Voluntary STD benefits payable: 1st day of Accident; 8th day of Sickness for a maximum benefit period of 26 weeks.
☐ Voluntary STD benefits payable: 15th day of Accident; 8th day of Sickness for a maximum benefit period of 26 weeks.

NON-MEDICAL MAXIMUM (amounts in excess of the amount stated are subject to satisfactory evidence of insurability)

Life: Basic $_____ Supplemental $ _____ Combined Basic and Supplemental $_____

STD: $ _____ Other: _____ $ _____

PART 3: ACTIVE WORK

It is understood and agreed that this application shall be made part of the Policy for which application is made. It is further understood:

1. Being **Actively at Work** is a requirement for coverage. If an employee is **not Actively at Work** on the day his coverage would otherwise be effective, the effective date of his coverage will be the date of his return to **Active Work**. If an employee does not return to **Active Work**, he will not be covered.
   The terms **"Actively at Work"** and **"Active Work"** mean that an employee is performing the Material and Substantial Duties of his occupation; is working the number of hours specified in Part 2, Schedule of Benefits; and satisfies any other conditions required by the applicable group Policy.
2. As of the proposed effective date (Item 6 above), are any of your employees **not Actively at Work** (as defined above) **and, therefore, not eligible for coverage?**

   ☐ Yes ☐ No If yes, please provide the following information: (Attach a signed dated sheet if more space is needed.)

A. Name_____ Sex _____ Date of Birth _____ Date Last Worked _____

Reason not Actively at Work: ☐ Disability ☐ Family Leave ☐ Other _____

B. Name_____ Sex _____ Date of Birth _____ Date Last Worked _____

Reason not Actively at Work: ☐ Disability ☐ Family Leave ☐ Other _____

PART 4: TERMS AND CONDITIONS

I, as the undersigned employer or other eligible membership organization ("Participating Employer"), hereby apply for coverage in the Council of Smaller Enterprises (COSE), a division of Greater Cleveland Partnership (GCP), group association insurance policy offered by MedMutual Life Insurance Company (MedMutual Life). I acknowledge that a copy of the group insurance policy is available at COSE's office for review by Participating Employers and employees. I acknowledge that no coverage can commence unless I receive written notice of approval from MedMutual Life's home office.

I agree that, upon acceptance and approval by MedMutual Life, I will, so long as such participation continues, fully comply with all obligations applicable to Participating Employers under the COSE policy as set forth therein. I understand that the insurance coverages under the group insurance policy will be only as provided for under the policy issued to COSE as the Policyholder. I acknowledge that COSE is not an insurer, and has no obligations regarding payment of premiums or handling of claims for the insurance provided under the group insurance policy issued to it as policyholder.

I understand that this insurance is subject to the approval of MedMutual Life, and nothing contained herein shall be binding upon MedMutual Life until this application is approved and accepted at MedMutual Life's home office. No waiver or change will bind MedMutual Life unless signed by an Executive Officer of MedMutual Life.

I certify that the information in this application is true and accurate to the best of my knowledge.I understand that the information in this application and any other information I provide shall serve as the basis for the coverage to be issued, and that I have a duty to notify MedMutual Life of any changes. I have relied upon no oral or written representations that contradict the aforementioned active-work information.

_____

Participating Employer Name and Title

_____

Authorized Representative's Signature

_____

Title Date

WARNING: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. (Ohio Revised Code Section 3999.21)

_____

Licensed Resident Agent (if required)